

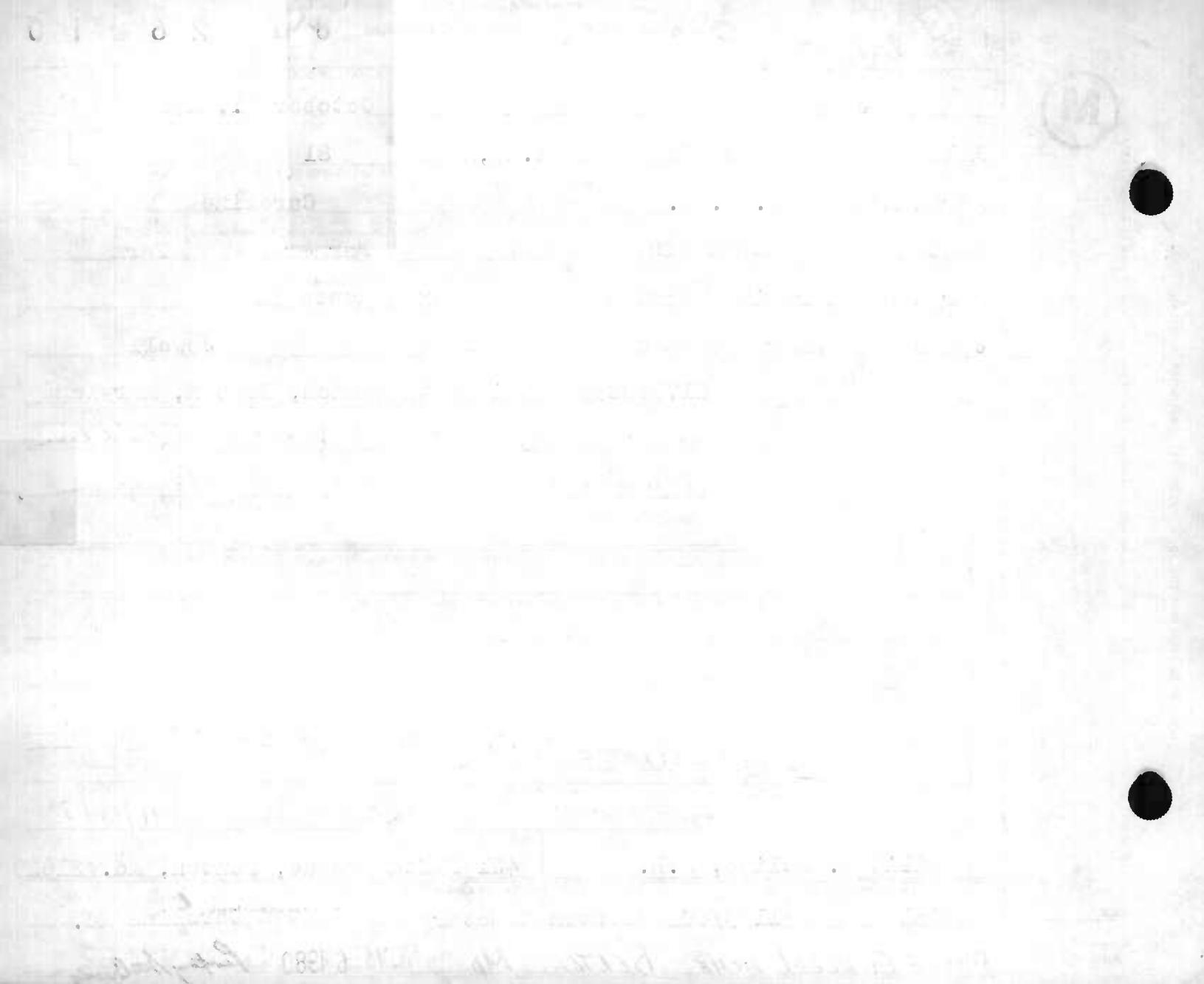
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										80 26010					
										REG. NO.					
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH			MONTH	DAY	YEAR	2b. HOUR			
James Madison Cannon						October 31, 1980						2p m			
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN			
Male		Caucasian		Sept. 25, 1899			81			YRS.					
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			10. CITY OR TOWN OF DEATH					
Maryland		U. S. A.					Caroline			Denton					
11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY			13a. STATE					
Route 328				Farmer			Farm			Maryland					
13b. COUNTY				13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS			14. FATHER'S NAME FIRST MIDDLE LAST		
Caroline				Denton			Route 328						James Henry Cannon		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)				16b. SOCIAL SECURITY NO.			17. INFORMANT			18. CAUSE OF DEATH (Enter only one cause per line for 1a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)				ADDRESS	
No				217360893			Elizabeth Cannon, Denton, Maryland							4100	
														Dental	
														year	
														year	
DUE TO, OR AS A CONSEQUENCE OF (b) <i>Arterio &amp; clut - carbo vascula</i>													Disease		
DUE TO, OR AS A CONSEQUENCE OF (c) <i></i>															
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a															
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED						20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN			COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 10/1/80, 19 21, to 10/2-180, 19, that (I) (was) (was) saw the deceased alive on 10/2/80, 19, and that in (my) (was) (was) opinion death occurred on the date and hour and from the causes stated above, (I) (was) (did) (did) view the body after death.													22b. SIGNATURE <i>Philip P. Felipe</i> MD		
22c. DEGREE													22d. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		
22e. ADDRESS													22f. DATE SIGNED 11/13/80		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORIAL			23d. LOCATION CITY OR TOWN			COUNTY STATE			
Burial			11/3/80			Denton Cemetery			Denton Caroline Md.						
24. FUNERAL DIRECTOR NAME			ADDRESS			25a. DATE REC'D. BY REGISTRAR			25b. REGISTRAR'S SIGNATURE						
MOORE FUNERAL HOME			DENTON, MD			NOV 6 1980			<i>Philip P. Felipe</i>						



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

0 2 6 0 1

FOR  
1 - STATE  
REGISTRAR

1. DECEASED NAME FIRST MIDDLE LAST  
Thomas Floyd Jackson

2a. DATE KNOWN  MONTH DAY YEAR 2b. HOUR  
OF ESTI-  
DEATH MATED 01018180 2P M

2. SEX 4 RACE 5. DATE OF BIRTH 6. AGE (IN YEARS  
MONTH DAY YEAR LAST BIRTHDAY)  
Male Caucas. Sept 4 05 75 YRS.  
IF UNDER 1 YR. IF UNDER 24 HRS.  
MONTHS DAYS HOURS MIN.

2c. DATE MONTH DAY YEAR 2d. HOUR  
PRONOUNCED DEAD 10/8/80 19 3:15PM

7a. BIRTHPLACE (STATE OR  
FOREIGN COUNTRY) 7b. CITIZEN OF WHAT COUNTRY? 8. MARRIED  NEVER MARRIED   
Maryland U. S. A. WIDOWED  DIVORCED

9. BALTIMORE CITY OR COUNTY OF DEATH  
Caroline MD

10. CITY OR TOWN OF DEATH 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION  
Goldsboro V 12a. USUAL OCCUPATION (TYPE OF WORK  
FOR MOST OF WORKING LIFE) 12b. KIND OF BUSINESS  
OR INDUSTRY  
Farmer Farm

13a. STATE 13b. COUNTY 13c. CITY OR TOWN 13d. INSIDE CITY LIMITS?  
Maryland Caroline Goldsboro YES  NO  RFD

14. FATHER'S NAME FIRST MIDDLE LAST 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST  
J. Alda Jackson Myra Wylie

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? 16b. SOCIAL SECURITY NO. 17. INFORMANT  
(YES, NO, OR UNKNOWN) (IF YES, GIVE WAR OR DATES) 577106181 ADDRESS  
No Grace Jackson, Goldsboro, Maryland

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  
PART 1 DEATH WAS CAUSED BY:  
IMMEDIATE CAUSE (a) Acute Myocardial Infarction APPROXIMATE INTERVAL  
410- minutes  
Conditions, if any, which  
gave rise to immediate  
cause (a) stating the under-  
lying cause lost. } DUE TO, OR AS A CONSEQUENCE OF  
(b) Coronary Sclerosis years  
DUE TO, OR AS A CONSEQUENCE OF  
(c) Generalized Arteriosclerosis yrs

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).

19a. DATE OF OPERATION 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? 20. AUTOPSY?  
YES  NO

21a. EXTERNAL CAUSE WAS 21b. TIME OF INJURY 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)  
UNDERLYING  OR HOUR A.M. MONTH DAY YEAR  
CONTRIBUTING  CAUSE OF DEATH P.M. 19

21d. INJURY OCCURRED 21e. PLACE OF INJURY (AT HOME, 21f. LOCATION  
WHILE  NOT WHILE  STREET CITY OR TOWN  
AT WORK  AT WORK STREET COUNTY STATE

22a. I certify that I took charge of the remains described above, held on Autopsy , Inspection , Inquiry , and in my opinion  
death resulted from: Natural causes , Accident , Suicide , Homicide , Undetermined manner

ACTUAL SIGNATURE Harold B. Plummer TITLE (SPECIFY) M.D. de deputy MEDICAL EXAMINER  
DATE SIGNED 10/11/80

EXAMINER'S NAME (TYPE OR PRINT) Harold B. Plummer M.D. ADDRESS Preston Maryland 21655

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) 23b. DATE 23c. NAME OF CEMETERY OR CREMATORIAL 23d. LOCATION  
Burial 10/11/80 Denton Cemetery CITY OR TOWN Denton County STATE Caroline Md.

24. FUNERAL DIRECTOR NAME ADDRESS 25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE  
Moore Funeral Home DENTON, MD. OCT 22 1980 Harold B. Plummer

M

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death, and be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours after death, with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

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STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												8	0	2	6	0	1	2					
												REG. NO.											
1. DECEASED NAME (TYPE OR PRINT)			FIRST			MIDDLE			LAST			2a. DATE OF DEATH			MONTH	DAY	YEAR	2b. HOUR FOUND 1:15P M					
Mrs. Edith S. LeGates												October 26, 1980											
3 SEX Female			4 RACE White			5. DATE OF BIRTH MONTH August			YEAR 1, 1896			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR		IF UNDER 24 HRS						
												84			MONTHS	DAYS	HOURS	MIN.					
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Federalsburg, Md.			7b. CITIZEN OF WHAT COUNTRY? U.S.A.			8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9 BALTIMORE CITY OR COUNTY OF DEATH Caroline			10a. CITY OR TOWN OF DEATH Preston			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) W. Main Street			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife			12b. KIND OF BUSINESS OR INDUSTRY Own Home		
13a. STATE Maryland			13b. COUNTY Caroline			13c. CITY OR TOWN Preston			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS W. Main Street											
14. FATHER'S NAME FIRST John			MIDDLE Thomas			LAST Stanton			15. MOTHER'S MAIDEN NAME FIRST Martha			MIDDLE Russell											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No			16b. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS			Preston, Md. 21655						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4100 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.			DUE TO, OR AS A CONSEQUENCE OF (b) ASHD			DUE TO, OR AS A CONSEQUENCE OF (c)			Mr. John S. LeGates, W. Main Street														
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) Osteosclerotic arteriosclerosis																							
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2																	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN			COUNTY			STATE								
22a. I certify that (I) (this hospital) attended the deceased from saw the deceased alive on 10/11/80, 19 80, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.			22b. SIGNATURE Wm Wood			DEGREE MD			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED 10/30/80											
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Wm Wood			22e. ADDRESS EASTON, MD																				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE Oct. 29, 1980			23c. NAME OF CEMETERY OR CREMATORIAL Junior Order Cemetery			23d. LOCATION CITY OR TOWN Preston, Caroline, Maryland			COUNTY			STATE								
24. FUNERAL DIRECTOR NAME Frampton-Hawkins Funeral Home			ADDRESS 216 N. Main St.			25. DATE REC'D. BY REGISTRAR NOV 5 1980			25. REGISTRAR'S SIGNATURE Liskey McCreary														



FOR STATE  
HEALTH DEPT.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, Md. 21201

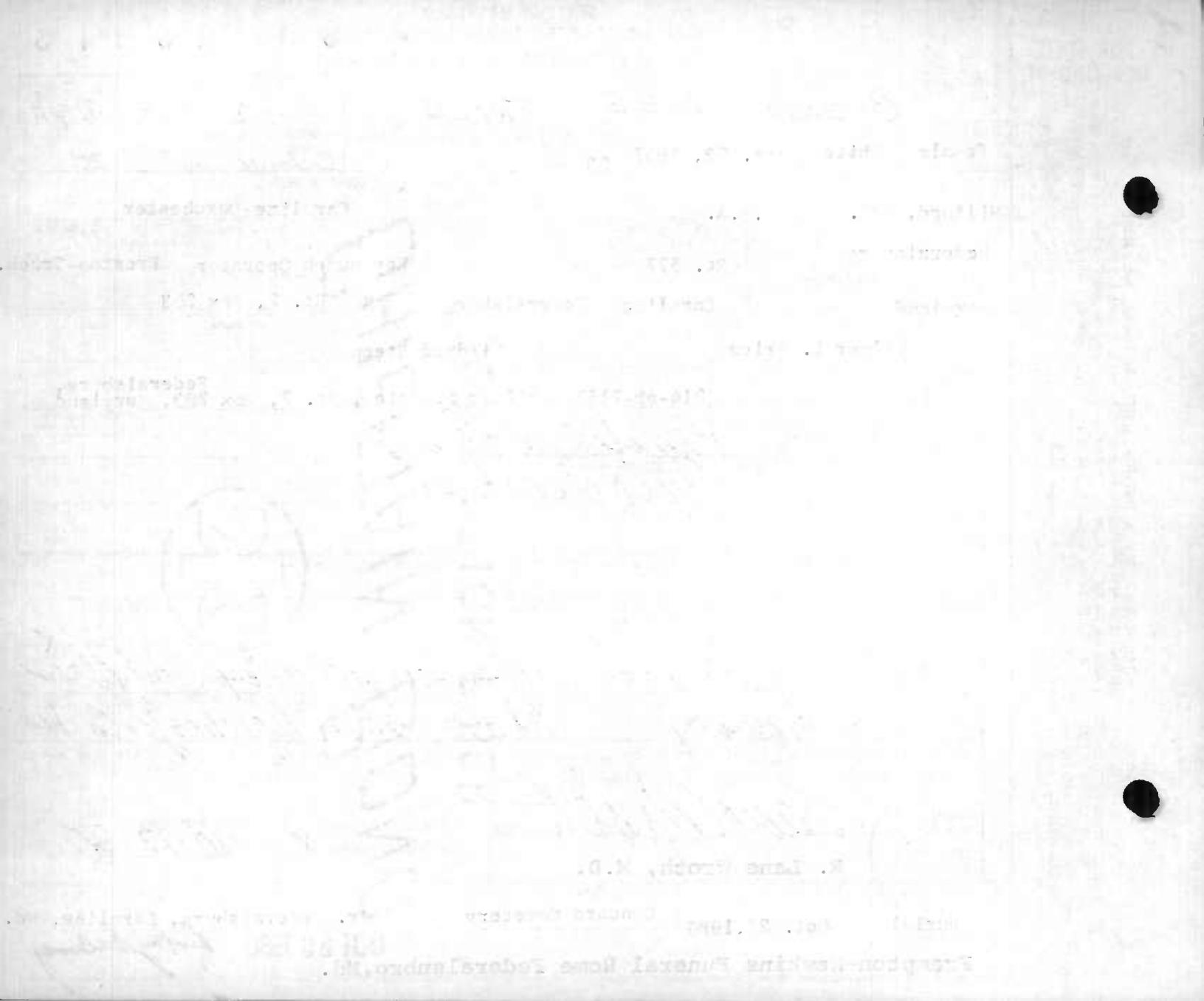
TO DEPUTY MEDICAL EXAMINER: This certificate should be executed, writing the word "pending" in pencil in item 18, Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health and Mental Hygiene prior to burial, cremation, or removal, and in any event within 72 hours of death.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

8 0 2 6 0 1 3

1. DECEASED-NAME (Type or Print)	First <i>BRENDA</i>	Middle <i>LEE</i>	Last <i>TRICE</i>	20. DATE KNOWN <input type="checkbox"/> Month <input type="checkbox"/> Day <input type="checkbox"/> Year OF ESTI- DEATH MATED <input checked="" type="checkbox"/> 10 25 1980	2b. HOUR 2 1/2 M
3. SEX <b>Female</b>	4. RACE <b>White</b>	5. DATE OF BIRTH <b>Apr. 23, 1957</b>	6. AGE (In years last birthday) <b>23</b> YRS.	IF UNDER 1 YEAR MONTHS <input type="checkbox"/> DAYS <input type="checkbox"/> HOURS <input type="checkbox"/> MIN <b>23</b> YRS.	2c. DATE PRONOUNCED DEAD Month <i>October</i> Day <i>25</i> Year <i>1980</i>
7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> X WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH <b>Caroline-Dorchester</b>	Md.		
10. CITY OR TOWN OF DEATH <b>Federalsburg</b>	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Rt. 577</b>	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>Key punch Operator</b>	12b. KIND OF BUSINESS OR INDUSTRY <b>Preston Truck.</b>		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Maryland</b>	13b. COUNTY <b>Caroline</b>	13c. CITY OR TOWN <b>Federalsburg</b>	13d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER <b>Rt. 2, Box 203</b>	
14. FATHER'S NAME <b>Wilmer L. Trice</b>	First <input type="checkbox"/>	Middle <input type="checkbox"/>	Last <input type="checkbox"/>	15. MOTHER'S MAIDEN NAME <b>Mildred Steen</b>	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>	16b. SOCIAL SECURITY NO. <b>214-68-7157</b>	17. INFORMANT <b>Wilmer L. Trice, Rt. 2, Box 203, Maryland</b>	ADDRESS <b>Federalsburg, Maryland</b>	APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Fractured skull</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b) <b>Auto accident</b> lost.					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(o)					
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH	21b. TIME OF INJURY Month, Day, Year HOUR A.M. <input type="checkbox"/> P.M. <input type="checkbox"/> <b>10-25 1980</b>	21c. HOW INJURY OCCURRED (Enter notation of injury in Part 2 or Part 2, item 18.) <b>apparently fell out of a car, went off road.</b>			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/>	21e. PLACE OF INJURY (At home, farm, street, factory, office, building, etc.) <b>Maryland</b>	21f. LOCATION Street or R.F.D. No. <b>Rt 577</b>	City or Town <b>50' in Dorchester Co. Md.</b>	County <input type="checkbox"/>	State <input type="checkbox"/>
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <i>R. Lane Wroth</i>	CHIEF MEDICAL EXAMINER <input type="checkbox"/> M.D.			ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	22b. DATE SIGNED <b>10-27-80</b>
EXAMINER'S NAME (Type) <b>R. Lane Wroth, M.D.</b>	ADDRESS (Street, city, town, or county) <b>Nr. Federalsburg, Caroline, Md.</b>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE <b>Oct. 28, 1980</b>	23c. NAME OF CEMETERY OR CREMATORIAL <b>Concord Cemetery</b>	23d. LOCATION (City or Town) <b>Nr. Federalsburg, Caroline, Md.</b>	(County) <input type="checkbox"/>	(State) <input type="checkbox"/>
24. FUNERAL DIRECTOR <b>Frampton-Hawkins Funeral Home Federalsburg, Md.</b>	ADDRESS <b>1001 W. Preston Street, Federalsburg, Md.</b>	25a. REC'D BY <b>OCT 30 1980</b>	25b. REGISTERED SIGNATURE <i>Henry Kelley</i>		



10  
FOR STATE  
HEALTH DEPT.

10  
RECORDS, 301 W. PRESTON STREET, BALTIMORE, Md. 21201  
TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

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DHMH-17 1/71 10M (VR A15ME (5))

10  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH  
26014

1. DECEASED-NAME (Type or Print)	First	Middle	Last	2a. DATE KNOWN OF ESTI- DEATH MATED	Month	Day	Year	2b. HOUR
Robert	A	Yerpe		10 26	80	1A	M	
3. SEX	4. RACE	S. DATE OF BIRTH	6. AGE (In years last birthday)	IF UNDER 1 YEAR	IF UNDER 24 HRS			2d. HOUR
Male	White	Jan. 31, 1923	57 yrs.	MONTHS	DAYS	HOURS	MIN.	2A M
7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED	NEVER MARRIED	<input checked="" type="checkbox"/>	9. COUNTY OF DEATH				
Pennsylvania	WIDOWED	DIVORCED	<input type="checkbox"/>	Caroline				
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY	
Preston	R. D. #1 Box 98D			Carpenter				
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS	13e. STREET AND NUMBER				
Md.	Caroline	Preston	YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	R.D. #1 Box 98 D				
14. FATHER'S NAME	First	Middle	Last	15. MOTHER'S MAIDEN NAME	First	Middle	Last	
Andrew			Yerpe	Ida	Susan		Munnich	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	16b. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS					
Yes	WW II	194-18-8670	Edith M. Weinmann see Item #13					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)								
PART I. DEATH WAS CAUSED BY:								
IMMEDIATE CAUSE (a) <u>MYOCARDIAL INFARCTION</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH								
410- DUE TO, OR AS A CONSEQUENCE OF								
Conditions, if any, which gave <u>ARTERIOSCLEROTIC CARDIOVASCULAR disease</u> chronic rise to immediate cause (a), stating the underlying cause } last. } (b) DUE TO, OR AS A CONSEQUENCE OF								
(c)								
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)								
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY?		
						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No.		City or Town	County	State
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>								
ACTUAL SIGNATURE <u>Christian E. Jensen MD</u> M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>								
EXAMINER'S NAME (Type) <u>Christian E. JENSEN MD</u> M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>								
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> ADDRESS (Street, city, town, or county)								
22b. DATE SIGNED <u>10/26/80</u>								
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORIAL	23d. LOCATION (City or Town)	(County)	(State)			
Burial	10-29-80	Md. Veteran's Cem.	Hurlock	Dorchester	Md.			
24. FUNERAL DIRECTOR	ADDRESS			25a. REC'D BY REGISTRAR	25b. REGISTRAR'S SIGNATURE			
Newnam Funeral Home	Easton, Md.			OCT 28 1980	<u>Victor McElroy</u>			

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